DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

May 25, 1990

ALL-COUNTY LETTER NO. 90-42

TO: ALL-COUNTY WELFARE DIRECTORS

SUBJECT: REVISED REPORT FORM (SOC 341) FOR SUSPECTED DEPENDENT ADULT AND ELDER ABUSE AND NEW INVESTIGATION FORM (SOC 343)

The attached camera ready copy of the Report of Suspected Dependent/Elder Abuse form (SOC 341, 4/90) with reporting instructions is a revision of the current form (7/88) and has been adopted by the State Department of Social Services (SDSS) in consultation with County Welfare Departments (CWDs), other State departments, various medical and nursing agencies, hospital associations, and law enforcement agencies. The changes to this form were necessitated by the provisions of Senate Bill (SB) 223 (Chapter 681, Statutes of 1989). In addition, several changes were made by SDSS to accommodate the needs of the CWDs and other government agencies.

The revised SOC 341 (4/90) will be printed in triplicate so that one or more of the copies will be available for cross-reporting to other agencies when required. The form is expected to be available in quantity from the SDSS Warehouse in July 1990 and may be ordered by submitting a GEN 727B, County Forms order to the following address: SDSS Warehouse, P.O. Box 22429, Sacramento, CA 95822-3799. Use of the current version of this form (7/88) should be discontinued upon receiving the revised forms.

Also attached is a camera ready copy of the new form, Investigation of Suspected Dependent Adult/Elder Abuse (SOC 343, 5/90) with instructions which was designed by the Adult Services Subcommittee of the County Welfare Directors Association (CWDA) for use by social worker staff in completing investigations of adult abuse and self-neglect reports. This is an optional form; however, Counties are encouraged to implement it because it serves as both a process guide and file documentation for investigations by social worker staff.

The SOC 343 is a two-page form printed in triplicate so that the CWDs may utilize one or more copies for statistical gathering purposes or for sharing with law enforcement agencies while one copy remains in the case file. Counties which tested this form in draft found it to be extremely beneficial in compiling statistics necessary to complete the mandatory Elder Abuse/ Dependent Adult Abuse Monthly Statistical Report form (SOC 340, 1/90) and the County Services Block Grant Programs Monthly Statistical Report form (SOC 242, 1/89). Counties that desire additional information on the implementation of the SOC 343 for statistical gathering purposes should contact their Regional Chairperson who will provide the name of a designated representative from a County currently utilizing the form in this manner.

Form SOC 343 is expected to be available from the SDSS Warehouse in July 1990 and may be ordered under the guidelines provided above.

If you have any questions concerning the revised reporting document or the new investigation form, please contact the Adult Services Bureau at (916) 322-6320.

LOREN D. SUTER
Deputy Director
Adult and Family Services

Attachments

cc: Department of Aging
Office of the State LTC Ombudsman
CWDA

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY | **CONFIDENTIAL** | DEPARTMENT OF SOCIAL SERVICES

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. SEE GENERAL INSTRUCTIONS ON REVERSE SIDE.

RECEIVING AGENCY USE ONLY

County APS/Ombudsman Case Number _____ SSN _____

Law Enforcement Case/File Number _____

A. VICTIM

NAME (LAST NAME FIRST):	AGE:	DATE OF BIRTH:	SEX: ☐ M ☐ F	RACE:	LANGUAGE (✓ CHECK ONE) ☐ NON-VERBAL ☐ ENGLISH ☐ OTHER *(SPECIFY)*
ADDRESS (IF FACILITY, INCLUDE NAME):			CITY		TELEPHONE ( )
PRESENT LOCATION (IF DIFFERENT FROM ABOVE):			CITY		TELEPHONE ( )

☐ DEVELOPMENTALLY DISABLED ☐ MENTALLY DISABLED ☐ PHYSICALLY HANDICAPPED ☐ BRAIN IMPAIRED ☐ FRAIL/ELDERLY (Functionally Impaired) ☐ HOSPITALIZED ADULT ☐ UNKNOWN

B. REPORTING PARTY

NAME (print)	SIGNATURE	OCCUPATION	DATE OF THIS WRITTEN REPORT
RELATION TO VICTIM	WHERE TO CONTACT: (STREET) (CITY) (ZIP CODE)		TELEPHONE ( )

C. INCIDENT INFORMATION

DATE/TIME OF INCIDENT(S)	PLACE OF INCIDENT (✓ CHECK ONE) ADDRESS _____	LEARNED OF INCIDENT BY (✓ CHECK ONE)
	☐ OWN HOME ☐ COMMUNITY CARE FACILITY ☐ HOSPITAL ☐ HOME OF ANOTHER ☐ NURSING FACILITY ☐ OTHER _____	☐ VERBAL REPORT ☐ OBSERVATION

D. REPORTED TYPES OF ABUSE (✓ CHECK ALL THAT APPLY).

1. PERPETRATED BY OTHERS

a. PHYSICAL
- ☐ ASSAULT/BATTERY
- ☐ CONSTRAINT OR DEPRIVATION
- ☐ SEXUAL
- ☐ PHYSICAL AND/OR CHEMICAL RESTRAINT, MEDICATION, ISOLATION (CIRCLE ONE OR MORE)
- ☐ OTHER *(SPECIFY)* _____

b. ☐ NEGLECT
c. ☐ ABANDONMENT
d. ☐ MENTAL SUFFERING
e. ☐ FIDUCIARY
f. ☐ OTHER *(SPECIFY)* _____

2. SELF-INFLICTED

a. PHYSICAL
- ☐ NEGLECT
- ☐ SUBSTANCE ABUSE
- ☐ OTHER PHYSICAL ABUSE

b. ☐ SUICIDAL
c. ☐ FIDUCIARY
d. ☐ OTHER *(SPECIFY)* _____

ABUSE RESULTED IN (✓ CHECK ALL THAT APPLY)
☐ NO PHYSICAL INJURY ☐ MINOR MEDICAL CARE ☐ HOSPITALIZATION ☐ CARE PROVIDER REQUIRED ☐ DEATH ☐ OTHER *(SPECIFY)* _____ ☐ UNKNOWN

E. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. *(LIST ANY POTENTIAL DANGER FOR INVESTIGATOR.) (ATTACH ADDITIONAL INFORMATION.)*

F. COLLATERAL CONTACTS *(INCLUDE PERSONS BELIEVED TO HAVE KNOWLEDGE OF VICTIM OR ABUSE, IF AVAILABLE)*

NAME	ADDRESS	TELEPHONE NO.	RELATIONSHIP

G. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM. *(IF UNKNOWN, LIST CONTACT PERSON).*

NAME	IF CONTACT PERSON ONLY ✓ CHECK ☐	RELATIONSHIP
ADDRESS		TELEPHONE ( )

H. RELATIONSHIP OF SUSPECTED ABUSER TO THE VICTIM

NAME OF SUSPECTED ABUSER

☐ CARE CUSTODIAN (type) _____ ☐ PARENT ☐ OFFSPRING ☐ OTHER (Specify) _____
☐ HEALTH PRACTITIONER (type) _____ ☐ SPOUSE ☐ OTHER RELATION

ADDRESS	TELEPHONE ( )	SEX ☐ M ☐ F	RACE	AGE	D.O.B.	HEIGHT	WEIGHT	EYES	HAIR

I. VERBAL REPORT MADE (Check one ☐ Reported to Agency (See No. 1-5 on reverse side) ☐ Received by Agency (See No. 6 on reverse side).)

AGENCY:	OFFICIAL CONTACTED:	TELEPHONE ( )	DATE:	TIME:

J. AGENCY USE ONLY

1. ☐ Evaluated/Investigation not warranted By:

2. Assigned ☐ ER ☐ Non-ER To:

3. Cross-Reported to: ☐ Ombudsman ☐ Law Enforcement ☐ CCL or Health Lic. ☐ Professional Board ☐ BMF & PA ☐ APS ☐ Other [Specify] _____

SOC 341 (4/90)

General Instructions

1. Mandated reporters are to complete this form for each incident and each victim of suspected physical abuse of a dependent adult or elder person within two (2) working days of the telephone report to your County Adult Protective Services (APS) agency or local long-term care ombudsman program or local law enforcement agency. This form may also be used by mandated reporters for permissive reporting of each incident and each victim of suspected other types of abuse of a dependent adult or elder person.
2. If any item of information is unknown, write "unknown" beside the item.
3. Mandated reporters (see below) are required to give their names.
4. If the suspected abuse is physical abuse send one copy of this report to the County Adult Protective Services Agency* or local law enforcement agency or if the suspected physical abuse occurred in a long-term care facility (i.e., nursing home, community care facility, residential care facility for the elderly, adult day health care center) send one copy of the report to the local long-term care ombudsman or a local law enforcement agency.
5. All reports of non-physical abuse may be sent to the local long-term care ombudsman if the suspected abuse occurred in a long-term care facility or to the County Adult Protective Services Agency if the suspected abuse occurred anywhere else.
6. This form is also to be used by the receiving agency to record information received through a telephone report of dependent adult\elder abuse. Complete shaded sections on the form when a telephone report of abuse is received as required by statute and the Department of Social Services.

Reporting Instructions

Purpose

This form, as adopted by the Department of Social Services, is required under Welfare and Institutions Code, Chapter 11, Division 9, Sections 15630(a)(1)(2) and 15633(a)(b).

Also, this form serves to document the information given by the reporting party on the suspected incident of physical abuse of an elder and dependent adult.. "Elder" means any person residing in this state, 65 years of age or older, "Dependent adult" means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations which restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. "Dependent adult" includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.

Reporting Responsibilities

Any elder or dependent adult care custodian, health practitioner, or employee of a county adult protective services agency* or a local law enforcement agency, who in his or her professional capacity or within the scope of his or her employment, either has observed an incident that reasonably appears to be physical abuse, has observed a physical injury where the nature of the injury, its location on the body, or the repetition of the injury, clearly indicates that physical abuse has occurred, or is told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, shall report the known or suspected instance of physical abuse either to the long-term care ombudsman coordinator or to a local law enforcement agency when the physical abuse is alleged to have occurred in a long-term care facility, or to either the county adult protective services agency*(or to a local law enforcement agency when the physical abuse is alleged to have occurred anywhere else, immediately or as soon as possible by telephone, and shall prepare and send a written report (SOC 341) thereof within two (2) working days.

When two or more persons who are required to report are present and jointly have knowledge of a suspected instance of elder abuse or abuse of a dependent adult and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by the selected members of the reporting teams. Any member who has knowledge that the member designated to report has failed to do so, shall thereafter make a report.

Any person knowingly failing to report, when required, an instance of elder or dependent adult abuse is guilty of a misdemeanor punishable by imprisonment in the county jail for a maximum of six months or fined $1,000 or both imprisonment and fine.

The identity of all persons who report under Chapter 11 shall be confidential and disclosed only between adult protective services agencies,* local law enforcement agencies, long-term care ombudsman coordinators, Bureau of Medi-Cal Fraud and Patient Abuse of the Office of the Attorney General, licensing agencies, or their counsel, the district attorney in a criminal prosecution, or upon waiver of confidentiality by the reporter, or by court order.

Reporting Party Definitions (Mandated Reporters)

Any elder to dependent adult care custodian, health practitioner or employee of a county adult protective services agency* or a local law enforcement agency:

"**Care custodian**" is defined as an administrator or an employee of any of the following public or private facilities which provide care for elders and dependent adults except persons who do not work directly with elder and dependent adults as part of their official duties (including support and maintenance staff):

24-hour health facilities [as defined in Health and Safety (H&S) 1250, 1250.2, 1250.3]
Clinics
Home health agencies
Adult day health care centers
Sheltered workshops
Camps
Respite care facilities
Residential care facilities for the elderly (H&S Code 1569.2)
Community care facilities (H&S Code 1502)
Regional center for persons with developmental disabilities
State Departments of Social Services and Health Services licensing divisions
County Welfare Departments
Patient's rights advocate offices
Office of the Long-term care ombudsman
Offices of public guardians and conservators
Secondary schools serving 18-22 year-old dependent adults and postsecondary educational institutions which serve dependent adults or elders
Any other protective or public assistance agency which provides health or social services to elders or dependent adults
[WIC Section 15610(h)]

"**Health Practitioner**" means:
Physician and surgeon
Psychologist
Resident
Intern
Chiropractor
Dental Hygienist
Licensed clinical social worker
Psychiatrist
Dentist
Podiatrist
Licensed nurse
Paramedic
Pharmacist
Optometrist

A marriage, family and child counselor trainee or unlicensed intern as defined in subdivision (c) of Section 4980.03 and Section 4980.44 respectively of the Business and Professions Code.
Marriage, family and child counselor or any other person licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
Any emergency medical technician I or II.
Any person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code.
State or county public health or social service employee who treats an elder or dependent adult for any condition.
Coroner.
Religious practitioner who diagnoses, examines or treats elders or dependent adults.
[WIC Section 15610(i)]

*"Adult protective services agency" means a county welfare department except persons who do not work directly with elders or dependent adults as part of their official duties including support and maintenance staff. [WIC Section 15610(j)].

INVESTIGATION OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE – Page 1

TO BE COMPLETED BY APS SOCIAL WORKER

DEPENDENT ADULT/ELDER NAME (LAST NAME FIRST)	APS CASE NO.	SSN — —

A. APS INVESTIGATION INFORMATION - ADDITIONAL SPACE ON PAGE TWO

1. DATE(S) AND TIME(S) OF INCIDENT(S)

2. DATE(S) AND TIME (S) INVESTIGATED BY APS

3. DESCRIBE CHARACTERISTICS OF VICTIM'S ENVIRONMENT (LIVING QUARTERS, ADEQUACY OF CARE, FINANCIAL ARRANGEMENTS, ETC.)

4. ABUSE/SELF-NEGLECT INDICATORS OBSERVED OR REPORTED AT TIME OF INVESTIGATION (CIRCLE ALL THAT APPLY)

a. Physical Indicators: Bruises Burns Welts Fractures Dislocations Lacerations Abrasions Skin Irritations Skin disorders Bedsores Friction burns Untreated injuries Untreated medical/dental problem Stomachaches Malnuturition Dehydration Pallor Sunken eyes/cheeks Fleas Lice/nits No food/water Signs of confinement Poor hygiene Unwashed clothing/bedding Inadequate heating Unsanitary conditions Unsafe housing

b. Behavioral Indicators: Fear Denial Trembling Implausible/conflicting stories Regressive behavior Helplessness Non-responsiveness Resignation Agitation Depression Sleeping disturbances Excessive sleeping

c. Sexual Abuse Indicators: Sexually transmitted disease Genital discharge/infection Genital trauma (Bruises, etc.) Difficulty walking/sitting Excessive body consciousness Fecal soiling Inappropriate sexual behavior

d. Fiduciary Indicators: Unusual bank account activity Inappropriate interest by relative/caretaker Isolated Numerous unpaid bills Lack of affordable necessities/amenities Promise of lifelong care Inappropriately executed/exercised Power of Attorney Forged signature Personal belongings/valuables missing Recent will/transfer of property

5. DESCRIBE PHYSICAL EVIDENCE OF ABUSE/SELF-NEGLECT (CLARIFY INDICATORS ABOVE OR INCLUDE ADDITIONAL INFORMATION)

6. DESCRIBE HOW/WHY ABUSE APPEARS TO HAVE BEEN COMMITTED (MAY INCLUDE WEAPONS USED, POSSIBLE MOTIVE, ETC.)

B. STATEMENTS - ADDITIONAL SPACE ON PAGE TWO. A SIGNED STATEMENT (OPTIONAL) MAY BE OBTAINED FROM ANY OF THE PARTIES LISTED BELOW.

7. VICTIM'S STATEMENT (INCLUDE REPORTS OF THREATS, INTIMIDATION, HARASSMENT)

8. ASSESSMENT OF VICTIM'S WILLINGNESS AND ABILITY TO COOPERATE WITH INVESTIGATION AND PROSECUTION

9. SUSPECTED ABUSER'S STATEMENT

10. STATEMENT(S) OF OTHER PERTINENT PARTIES (INCLUDE ADDRESS/TELEPHONE NUMBER IF NOT ON SOC 341)

11. ARE OTHER AGENCIES INVOLVED IN INVESTIGATION? ☐ YES ☐ NO IF SO, GIVE AGENCY NAME AND NAME AND TELEPHONE NUMBER OF CONTACT PERSON:

PRINT APS SOCIAL WORKER NUMBER	SIGNATURE OF APS SOCIAL WORKER

INSTRUCTIONS FOR COMPLETING THE SOC 343
Page 1

Heading - Give client's name, APS case number and social security number.

Part A - APS Investigation Information

1. Give date(s) and time(s) of incident(s) as reported.

2. Give date(s) and time(s) the incident(s) are actually investigated by APS.

3. Describe the pertinent characteristics of the victim's environment including conditions of his/her present living quarters, the adequacy of care being provided, what types of financial arrangements the victim has, etc.

4. Circle all the abuse/self-neglect indicators that are observed or reported by the victim at the time of the APS investigation.

5. Describe the physical evidence of abuse/self-neglect observed or reported by the victim at the time of the APS investigation. This section may be used to clarify the indicators reported under A.4. above.

6. Describe how or why the abuse appears to have been committed. This requires a subjective determination by the APS worker performing the investigation.

Part B - Statements

7. Summarize the victim's statement as given to the APS worker performing the investigation.

8. Give an assessment of the victim's willingness and ability to cooperate with an investigation and prosecution. This requires a subjective determination by the APS worker doing the investigation.

9. Summarize the suspected abuser's statement.

10. Summarize the statements of any other pertinent parties, identifying the person by name, address and telephone number if this information is not already included on the SOC 341.

11. Indicate if other agencies are involved in the investigation. If so, give the agency name and telephone number of a contact person.

INVESTIGATION OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE – Page 2

TO BE COMPLETED BY APS SOCIAL WORKER

DEPENDENT ADULT/ELDER NAME (LAST NAME FIRST)	APS CASE NO.	SSN — —

C. USE THIS SPACE FOR ADDITIONAL INFORMATION OR STATEMENTS

IF CONTINUATION FROM PAGE 1, GIVE ITEM NO. (1-11)
ITEM NO:

D. OUTCOME OF APS INVESTIGATION

12. ☐ TRANSFERRED TO NON ER DATE TRANSFERRED:

13. ☐ ABUSE NOT CONFIRMED

14. ☐ ABUSE CONFIRMED: *(✔ check all that apply)*

1. ☐ PERPETRATED BY OTHERS

a. PHYSICAL
- ☐ ASSAULT/BATTERY
- ☐ CONSTRAINT OR DEPRIVATION
- ☐ SEXUAL
- ☐ PHYSICAL AND/OR CHEMICAL RESTRAINT, MEDICATION, ISOLATION (CIRCLE ONE OR MORE)

b. ☐ NEGLECT
c. ☐ ABANDONMENT
d. ☐ MENTAL SUFFERING
e. ☐ FIDUCIARY
f. ☐ OTHER (SPECIFY) _____

2. SELF-INFLICTED

a. PHYSICAL
- ☐ NEGLECT
- ☐ SUBSTANCE ABUSE
- ☐ OTHER PHYSICAL ABUSE

b. ☐ SUICIDAL

c. ☐ FIDUCIARY
d. ☐ OTHER (SPECIFY) _____

15. COMMENTS

PRINT APS SOCIAL WORKER NUMBER	SIGNATURE OF APS SOCIAL WORKER	SIGNATURE OF APS SUPERVISOR

INSTRUCTIONS FOR COMPLETING THE SOC 343
Page 2

Heading - *Give client's name, APS case number and social security number.*

Part C - Additional Space

Use this additional space to continue any items under parts A or B on Page 1.

Part D - Outcome of APS Investigation

12. Check this box if the case was transferred to non ER (Emergency) status. Give the date transferred.

13. Check this box if the abuse report was not confirmed.

14. Check this box if the abuse was confirmed. Indicate if the abuse was perpetrated by others (1a-1f) or if the abuse/neglect was self-inflicted (2a-2d).

15. Use this space for any additional comments.